STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	06/24/2019

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LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

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4 000	Initial Comments A state re-licensure survey was conducted at the facility from 06/18/2019 - 06/24/2019. The facility's census was 232 residents at the time of entrance.	4 000		
4 099	11-94.1-22(a) Medical record system (a) The facility shall have available sufficient appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, auditing and analysis, indexing, filing, and prompt retrieval of records, record data, and resident health information. This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure documentation of side effects related to the use of antidepressant, anti-anxiety, and antipsychotic medication was systematically consistent and accurate. Findings Include: Resident (R)114 was admitted to the facility on 03/14/17. R114's diagnoses include: mood disorder due to known physiological condition with depressive features; transient cerebral ischemic attack; major depressive disorder, recurrent, severe with psychotic symptoms; and generalized anxiety disorder. A record review was done on 06/20/19 at 10:40 AM. A review of the physician orders included: Abilify 10 mg. in the evening related to depressive disorder, recurrent, severe, with psychotic symptoms; sertraline 100 mg. two times a day related to mood disorder due to known	4 099	Point 1 □ How corrective action will be accomplished for those residents found to have been affected by the deficient practice. For resident #114, Medication Administration Record (MAR)for antidepressant side effect monitoring was corrected on 6/24/19. Point 2 □ How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was completed for medication monitoring side effects for all residents on an antidepressant, antipsychotic and antianxiety. Three discrepancies were corrected at time of discovery. Point 3 □ What measures will be put into place or systemic changes made to ensure that the deficient practice will not	7/24/19

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4 099	Continued From page 1 physiological condition with depressive features; and Ativan 1 mg. orally four times a day related to adjustment disorder with mixed anxiety and depressed mood, generalized anxiety disorder panic attacks. The order also included to monitor for the side effects of antipsychotic (Abilify), antianxiety (Ativan) and antidepressant (sertraline). The order includes to monitor every shift and document (+) if side effects are present and write a progress note and document (-) if no side effects are present. A review of the Medication Administration Record (MAR) for June 2019 found entries with an (X) code. On 06/20/19 at 11:20 AM an interview and concurrent record review was done with Unit Manager (UM)2. The UM explained the (+) indicates a side effect was present and the nurse will make a corresponding entry in the residents' progress note. UM2 further explained if a (-) is documented, that would indicate no side effects were present. The UM was asked what does the (X) coding indicate as there were entries with an (X) for antipsychotic medications during the day shift for 06/0719, 06/08/19, 06/09/19, 06/10/19; the evening shift for 06/01/19 through 06/09/19, 06/11/19 through 06/14/19, and 06/18/19 and 06/19/19; the night shift for 06/0/19, 06/08/19 and 06/09/19. Concurrent record review with UM2 found documentation in the MAR for side effects related to the use of antianxiety and antidepressant medications. A review of the May 2019 documentation also found the use of (X) coding. The UM confirmed the MAR for the side effects of these medications has documentation of (X). UM2 was unable to identify what the (X) coding indicates in the MAR documentation for side effects related to use of antipsychotic,	4 099	recur. On 7/12/19 Unit managers/nursing supervisors received targeted in-service on importance to review orders for psychoactive RX side effect monitoring is systematically consistent. On 7/15/19 licensed staff received targeted in-serve education on importance of consistent, accurate documentation of side effects of antidepressant, antipsychotic and antianxiety medication. Point click care template for monitoring side effects of psychoactive medications were corrected to prevent further occurrence. Point 4 □ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. DON/designee will audit 10 e MAR antidepressant, antipsychotic and antianxiety medication side effects weekly to ensure documentation is consistent and accurate for the next 30 days.. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5 □ Date corrective action will be	

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4 099	Continued From page 2 antianxiety and antidepressant medications. A request was made for the facility's policy and procedures for coding side effects in the MAR. UM2 responded she would follow up with the software instructions for coding. Upon exit, no further documentation or information was provided.	4 099	completed. July 24, 2019	
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observation, interview with family member and record review, the facility did not ensure provision of sufficient numbers of nurse staffing to provide care to all residents to maintain their highest physical well-being for a resident (Resident 5) experiencing insidious weight loss. Findings Include: Resident (R)5 was admitted to the facility on 01/11/19 with the following diagnoses: (idiopathic) normal pressure hydrocephalus; ataxic gait; muscle weakness; dysphagia oropharyngeal phase; cognitive communication deficit; type 2 diabetes mellitus without complications; chronic kidney disease, and cardiomyopathy.	4 148	Point 1 □ How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #5 was provided assistance from staff to complete her meal. Point 2 □ How the facility will identify other residents having the potential to be affected by the same deficient practice. On 7/10/19 an audit was completed to identify all residents who require assistance with meals and to establish that a process is in place to provide assistance with meals at the time of tray delivery. The audit determined that 14	7/24/19

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4 148	Continued From page 3 On 06/18/19 at 12:00 PM, lunch observation found R5 in bed with her mother visiting. Mother reported R5 had returned from hemodialysis. Upon query, Mother reported R5 has had a weight loss. Further inquired what is the facility doing about the weight loss, Mother replied she is not sure what is being done. However, Mother reported R5 is on a renal/diabetic diet which is controlling R5's diabetes. R5's lunch tray was on the bedside table. The plate was uncovered, the resident had pureed food. The brown pureed item formed a crust and appeared dry. Mother also reported R5 does not want to be fed by her and prefers to be fed by staff member. At 12:26 PM, R5 was still waiting to receive assistance with her meal. On 06/19/19, R5's mother reported concern that R5 has to wait to receive assistance for her meal. R5's mother reported the staff are working hard; however, there isn't enough staff members to assist residents with their meals. On 06/20/19 at 11:34 AM observed mother visiting R5. R5's lunch tray was on the bedside table, there was no staff member assisting R5 with her meal. Second observation at 11:47 AM, R5 was still waiting for assistance. The observation at noon found a staff member assisting R5 with her lunch. On 06/21/19 at 09:10 AM, R5 was receiving assistance from the Speech-Language Therapist (SLP)1 during breakfast. A brief interview was conducted, SLP1 reported R5 is being assessed for graduation from pureed food. On 06/18/19 at 12:31 PM a record review found R5 had a 5% weight loss in three months. On 03/02/19 R5 weighed 129 lbs. and on 06/10/19	4 148	residents require assistance with meals. Point 3 □ What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/28/19 Staff received directed in-service education on the facilities revised process for meal tray delivery. See Exhibit A. On 7/10/19 Licensed and un-licensed staff received targeted in-service education on implementation of new dining room process, including transporting and assisting residents with their meals. On 7/12/19 All staff received targeted in-service education on importance of residents receiving food that is palatable, served at a proper temperature and at appropriate times. Staff received targeted in-service of process for licensed and un-licensed staff to assist with transportation to/from dining room and licensed staff to assist residents with their meals. 7/15/19 and 7/16/19 Direct care staff received targeted in-service education on importance of ensuring residents receive food that is palatable, served at a proper temperature and at appropriate times and licensed and un-licensed staff to assist with transportation to/from dining room and licensed staff to assist residents with their meals. Staff received targeted in-service education on timeliness of assisting residents with meals.	

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4 148	Continued From page 4 weighed 122 pounds. A review of R5's Minimum Data Set with an assessment reference date (ARD) of 03/03/19 for significant change notes in Section G. Functional Status R5 is totally dependent with one-person physical assist for eating. The previous comprehensive assessment with an ARD of 01/18/19 notes R5 required limited assistance with one-person physical assist for eating. On 06/20/19 at 05:10 PM interview with Unit Manager (UM)2 found the ratio of Certified Nurse Aides (CNAs) is one to eight residents. On 06/20/19 at 05:40 PM an interview was conducted with the Registered Nurse (RN)1. The RN reported during dinner there is usually three to four CNAs and two charge nurses. The nurses reportedly will assist residents with meals, for a total of five to six staff members available for meal assistance. RN1 reported there are nine residents on the unit that require total assistance during meal time.	4 148	Point 4 □ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. DON/designee will audit 20 meal tray deliveries at least 5x a week for either breakfast, lunch or dinner for the next 30 days to ensure trays are delivered timely and necessary assistance is provided. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5 □ Date corrective action will be completed. July 24, 2019	
4 155	11-94.1-40(c) Dietary services (c) A nutritional assessment and care plan shall be recorded in each resident's medical record and integrated into the overall comprehensive assessment and overall plan of care coordinated/integrated with all disciplines. The nutritional assessment and care plan shall be reviewed on a regular basis and adjusted as needed. This Statute is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to ensure 1 (Resident 102) of 10 residents sampled	4 155	Point 1 □ How corrective action will be accomplished for those residents found to have been affected by the deficient	7/24/19

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4 155	Continued From page 5 for weight loss received the care to maintain acceptable parameters of nutrition. A resident with an unavoidable weight loss has regained any weight since the loss. The facility did not assess causal factors that may be contributing to the resident's inability to return to her usual body weight. Findings Include: Resident (R)102 was admitted to the facility on 08/11/16. The diagnoses include: unspecified dementia without behavioral disturbance; unspecified abdominal pain; dysuria; history of falling; wandering; type 2 diabetes mellitus without complication; adjustment disorder with depressed mood; and subsequent encounter for closed fracture with routine healing; and unspecified fracture of first lumbar vertebrae. On 06/18/19, R102 was observed in her room having lunch. R102 was seated at the side of her bed with bedside table over her lap. R102's meal consisted of chicken, salad, rice, cake, coffee and juice. R102 was able to feed herself using regular utensils. R102 was not eating and had consumed approximately 25% of her meal. R102 was asked if she was done, she shook her head, "Yes". On 06/20/19 at lunch, R102 was observed sitting up and feeding herself. The meal consisted of laulau (pork wrapped with luau leaves), rice, lomi salmon and poi. The resident was observed to actively feed herself and had consumed approximately 50% of her laulau. On the morning of 06/19/19 at 10:58 AM a record review was done. On 06/03/19, R102 weighed 90 lbs. On 03/01/19 the resident weighed 107 lbs., which reflects a 16% weight loss in three months. A comparison of weights from 03/01/19 at 107	4 155	practice. Resident #102 was offered to move to the dining room for meals but refused. In addition, the following were completed for resident #102: On 6/21/19 Miralax 17 gram PO daily was added to proactively to address constipation. On 7/12/19 Mirtazapine7.5 mg PO at bedtime was started. Resident□s care plan was updated to reflect new nutritional goal as regaining the weight is not anticipated. On 6/24/19 Complete blood count, Comprehensive metabolic profile and TSH was done. Results indicating acceptable nutritional and hydration status were within normal limits. At the time of lab draw, weight was 91.4 pounds. Point 2 □ How the facility will identify other residents having the potential to be affected by the same deficient practice. On 7/16/19 an audit was completed for nutrition care plans of residents with significant change of status assessments to ensure care plans reflected nutritional goals, refusals of weights and/or other concerns that may contribute to poor meal intake. On 7/16/19 an audit was completed of residents with significant change of status assessments to ensure residents maintain acceptable nutritional parameters to reduce the risk of weight loss unless their clinical condition demonstrates this is not	

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4 155	Continued From page 6 lbs. and 04/01/19 at 94 lbs. shows a weight loss of 12% in one month. A progress note dated 04/03/19 notes R102 with significant weight loss and the resident was started on supplement (2 Cal HN, 50 ml, three times a day). A review of the Minimum Data Set with assessment reference date (ARD) of 04/15/19 for a significant change notes in Section K. Swallowing/Nutritional Status, R102 had a significant weight loss and was not on a physician-prescribed weight loss regimen. A progress note dated 04/16/19 documents R102 was identified for significant change in activities of daily living functioning, bladder status, behavior changes and weight loss. The resident was also noted with poor PO intake of solid foods. The resident also reportedly refused weekly weight. The resident's care plan indicates a goal for the resident to consume at least 50% of most meals and will not experience further significant weight loss through next review date. The revised interventions include the following: encourage po intake of meals, snacks, supplements and fluids; honor meal preferences, enjoys snacks from family, likes prune juice, coffee and papaya; and provide diet and supplements as ordered. A review of the Registered Dietitian (RD) Nutrition Data Collection/Assessment dated 04/16/19 documents the resident's current weight as 92 lbs. The usual body weight was 103 to 108 lbs. and ideal body weight of 83 to 102 lbs. The RD notes, R102's intake has decreased, consuming 0-25% of meals. The RD also notes R102 had an acute illness in March. The progress note dated 05/02/19 documents R102 was discussed by IDT due to recent weight	4 155	possible. Audit included, but not limited to - resident eating location, assessment of other factors which may impact meal intakes, interventions are in place and the resident's weights are being monitored weekly. Point 3 □ What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 7/10/19 MDS coordinators received targeted in-service education on importance of assessing to determine causal factors that may contribute that may contribute to the inability to return to usual body weights. On 7/15/19 and 7/16/19 direct care staff received targeted in-service education on importance of weight and meal intake monitoring, location of meals to promote meal intake and offering of snacks between meals. Residents who have an acute illness will be moved to weekly weight monitoring. Residents who have a 3% weight loss will be reviewed in Resident at Risk meetings each week until weight has stabilized. Residents who have meal intakes of 25% will be reviewed and discussed in the weekly Resident at Risk meeting and well as on rounds. Point 4 □ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued	

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4 155	Continued From page 7 loss. The PO intake documents 0 to 50% consumption at meals and the resident was drinking supplements (2 Cal HN). The resident also weighted 98 lbs. on 05/01/19. Subsequent note of 05/13/19 documents R102 was discussed in grand rounds for decreased PO intake. The resident had a trial of Ensure Clear which was effective and there was an increase of 2 Cal HN (60 ml) to three times a day. On 06/21/19 at 07:57 AM an interview was conducted with Minimum Data Set Coordinator (MDS-C)1. Inquired what were the identified causal factors contributing to R102's weight loss? MDS-C1 responded the loss was due to progression of R102's dementia. R102 was discussed with the interdisciplinary team (IDT) and supplements and snacks were added. Inquired whether IDT documented R102's significant weight loss is contributed to the progression of dementia and that she is entering advance stage of the disease. The coordinator reported the resident was identified with weight loss and interventions were implemented. On 06/21/19 at 08:09 AM an interview and concurrent record review was done with the Director of Nursing (DON). The DON reported R102 had influenza A in March, she was treated with Tamiflu (five-day course, starting 03/29/19). The DON also identified R102 was moved from the dementia locked unit to her current unit, which was another change that may have attributed to the resident's weight loss. The physician's summary dated 06/03/19 documents R102 was treated for influenza A (03/27/19) and is back to baseline, functionally. A review of the weights found R102 had a spike in weight on 05/01/19 (98 lbs.).	4 155	effectiveness of the systemic changes. Registered dietician/designee will audit weekly to ensure residents maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range unless the resident□s clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. The results of the reviews will be documented at the routine Resident at Risk (RAR) meeting and presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5 □ Date corrective action will be completed. July 24, 2019	

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The DON noted an entry for 04/02/19 which documents R102 with recent illness, elevated temperature and positive for influenza with noted decrease in meal intake since illness. R102 also noted with an unwitnessed fall on 04/01/19.

Also noted is R102 with constipation. R102 is prescribed with senokot 8.6 mg. if no bowel movement after second day and Dulcolax suppository 10 mg. if no bowel movement after third day. A review of the MAR found Dulcolax suppository was required due to ineffective results of the senokot in May and June 2019. The DON reported constipation is probably related to use of morphine to manage the resident's pain. Further queried whether constipation would affect the resident's meal intake and whether R102 ate in the dining area while on the dementia unit or prefers to eat alone as she takes meals in her room. The DON was not sure whether it is R102's preference to eat alone.

The DON reported in response to the resident's weight loss, the team has increased the resident's supplements from 2 Cal, 120 ml every morning to 2 Cal HN, 80 ml three times a day at med pass (04/16/19). R102 is documented to drink 25 to 100% of supplement. The Ensure Plus was discontinued on 06/06/19 as resident did not like it, too sweet.

On 06/21/19 at 09:23 AM an interview was conducted with the RD. The RD reported R102's weight loss was unavoidable as she had an acute illness. The RD also reported R102 is within her ideal body weight. Further queried why does the resident have a decrease in PO intake, consuming 0-25% of meals of her meals and has not been able to regain weight. The RD

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4 155	Continued From page 9 responded the facility has identified food preference and the family also brings R102 food from outside. Inquired whether the facility knows when the family brings food and how much of the outside food is consumed. The RD did not confirm the facility monitors outside food consumption. The RD stated she "speculates" this may be the resident's new baseline weight.	4 155		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure for one of five residents (Resident (R) 126) selected for review for limited range of motion (ROM) services, that the resident's comprehensive care plan was revised by the interdisciplinary team after the January quarterly assessment and after the April 2019 significant change assessment was done. Findings Include: On 06/19/19 at 10:19 AM and on 06/21/19 at 08:30 AM, observations and interview with R126 noted she had stiffness to her bilateral lower extremities (BLE), and to her bilateral upper extremities (BUE). During an interview with registered nurse (RN)1, she said the resident has passive range of motion (PROM) done with	4 175	Point 1 □ How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/21/19 restorative care plan was discontinued for resident #126. Point 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. On 7/10/19 an audit of all residents whose orders for restorative nursing services were discontinued over the past 6 months was completed. No further concerns identified. Point 3 □ What measures will be put into	7/24/19

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4 175	Continued From page 10 restorative nursing three to five times a week. When RN1 was asked how she knew the PROM was being done for this resident, RN1 stated she would have to check on this. Random observations of R126 found no PROM being done for the resident. Although R126 expressed the staff were very careful during her bed transfers because of her stiffness, she was uncertain about any exercise program that staff provided. A concurrent record review with RN1 found R126 had an active care plan for, "Restorative Range of Motion: Passive. Resident has contractures r/t (related to) Rheumatoid Arthritis." The interventions were for R126's BUE contracture management which was to be performed 3-5x (times) a week as tolerated. On 06/21/19 at 08:38 AM, during an interview with RN2, she stated the resident could make her own needs known, and would either agree or refuse services. RN1 further stated for R126, "Currently, I don't have her working with RNA (restorative nurse aide)." However, during the record review, RN1 found a 03/03/19 order to discontinue the resident's PROM. RN1 confirmed the care plan thus should have been revised/updated to reflect the discontinuation of services and affirmed that R126 was not receiving services. Further, RN1 stated on 01/23/19, as R126 had been doing her own exercises, the interdisciplinary team (IDT) decided to discontinue the PROM to her BUE. RN1 said for R126's BLE, "I know she has rheumatoid arthritis and has been that way since she came to us." RN1 said R126 had refused to see the rheumatologist and had previously received	4 175	place or systemic changes made to ensure that the deficient practice will not recur. On 7/10/19 MDS coordinators received targeted in-service education on importance of updating restorative care plans with each review and with new orders or discontinuation of restorative orders. MDS coordinators were assigned MDS courses in Health Care Academy focusing on care planning. On 7/15/19 Licensed staff received targeted in-service education on importance of updating care plans to reflect current orders. Residents who have a new order to start or discontinue restorative nursing, a care plan will be initiated or resolved. A communication form will be initiated for residents who has orders to start or discontinue restorative services and will be routed to MDS coordinators. Point 4 □ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. DON/ designee will audit new or discontinued orders for restorative nursing services weekly for 30 days to ensure restorative care plans are active or discontinued. The results of the reviews will be presented at the Quality Assurance	

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	125040	A. BUILDING: _____ B. WING _____	06/24/2019

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4 175	Continued From page 11 PROM to her BLE. During an interview with MDS-C3, she stated the last MDS assessment was done on 04/22/19 for a significant change in status assessment (SCSA). She verified the care plan which RN1 identified for the restorative ROM had not been revised, and further, it should have been effectively discontinued on 01/23/19 when her prior quarterly MDS assessment was done. MDS-C3 also said with the SCSA done in April, she overlooked the care plan for this area. MDS-C3 said she just discontinued this active care plan for the restorative ROM on 06/21/19. Per MDS-C2, she verified that 01/23/19 was the actual date to discontinue R126's restorative services. MDS-C2 verified the care plan should have been revised to reflect this. MDS-C2 said it may have been miscommunication with nursing, who saw the discontinuation date as 03/03/19, but also did not revise the care plan at that time.	4 175	and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5 □ Date corrective action will be completed. July 24, 2019	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to post notification signage of Contact Precautions at the entrance doorway of Resident (R) 145's room. This	4 203	Point 1 - How corrective action will be accomplished for those residents found to have been affected by the deficient practice.	7/24/19

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4 203	Continued From page 12 deficient practice put anyone at risk of being exposed to R145's known condition of Herpes Zoster (Shingles). Findings Include: During an observation of R145's room, on 06/18/19 at 10:50 AM, there was no posted signage at the entrance doorway which would have identified R145 as being on Contact Precautions. Thus, anyone could have entered the room not knowing that Contact Precautions were indicated. On 06/18/19 at 11:00 AM, Certified Nursing Assistant (CNA) 2 was queried about the Contact Precautions for R145. CNA2 stated that Contact Precautions were in place, but did not know why there was no posted signage at the entrance doorway at that time. CNA2 also said that other residents may have removed the sign. During an interview with Unit Manager (UM) 1 on 06/18/19 at 11:05 AM, UM1 acknowledged that a sign should have been posted at the doorway entrance of R145's room. UM1 further assured that the proper signage would be posted accordingly. During review of facility policy titled "Transmission-based Precautions and Isolation Procedures", it stated the following: Transmission-based precautions are implemented based upon the means of transmission of an infection (contact...) in addition to standard precautions in order to prevent or control infection... When a resident is placed on transmission-based precautions, the staff should implement the following: Clearly identify the type of precautions and the appropriate PPE to be	4 203	On 6/18/19 Contact precautions signage was posted on doorway of resident #145. Point 2 □ How the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/18/19 audit of residents on anti-infective medication revealed no other residents who required contact precautions. Point 3 □ What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. With noting of orders of anti-infective medication requiring transmission based precautions, notification signage will be placed. Weekly monitoring at infection control meeting any resident who may require transmission based precautions. During rounds any resident on transmission based precautions room will be checked for proper signage. On 7/12/19 all staff received targeted in-service education on importance of transmission based precautions and isolation procedures policy to decrease risk of exposure to infections. On 7/15/19 and 7/16/19 direct care staff received target in-service education on transmission based precautions and isolation procedures policy and use of	

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4 203	Continued From page 13 used, place signage in a conspicuous place outside the resident's room such as the door or on the wall next to the doorway identifying the CDC category of transmission-based precautions (e.g. contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure signage also complies with residents' rights to confidentiality and privacy...	4 203	signage. Point 4 □ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. SDC/designee will audit order daily to ensure notification signage is placed for residents on transmission based precautions for the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5 □ Date corrective action will be completed. July 24, 2019	
4 280	11-94.1-65(e)(7) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (7) Beds shall be placed at least three feet apart; and This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to ensure residents' beds are placed at least three feet apart. Findings include:	4 280	Point 1 □ How corrective action will be accomplished for those residents found to have been affected by the deficient practice.	7/24/19

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4 280	Continued From page 14 On 06/18/19 at 09:45 AM an initial tour of the unit found residents' beds spaced less than three feet apart in rooms 204, 213, and 220. On 06/21/19 at 11:05 AM concurrent observation was done with the Administrator. The Administrator reported the floor tile blocks are 12 x 12 inches and based on the number of tiles between the beds, the Administrator confirmed there was less than three feet between residents' beds in the following rooms: Room 204 (between Beds A and B); Room 213 (between Beds A and B, and between Beds B and C); and Room 220 (between Beds A and B).	4 280	Beds in room 204, 213 and 220 were adjusted to ensure beds were placed at least 3 feet apart. Point 2 □ How the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/21/19 an audit was completed for all beds in house to ensure beds were placed at least 3 feet apart. Any beds not meeting this requirement were corrected at time of discovery. Point 3 □ What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 7/12/19 All staff received targeted in-service education on construction requirement of beds being at least 3 feet apart. On 7/15/19 and 7/16/19 direct care staff received targeted in-service education on construction requirement of beds being at least 3 feet apart. Housekeepers to check daily to ensure there is at least 3 feet between beds as part of their daily checklist. Point 4 □□ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.	

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4 280	Continued From page 15	4 280	Director of maintenance/designee will audit 3 rooms a week to ensure beds are placed at least 3 feet apart for the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5 □ Date corrective action will be completed. July 24, 2019	